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Children's Behavioral Health and Implementation of the School Responder Model

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Introduction

Innovative research by Shufelt and Cocozza established the overwhelming prevalence of behavioral health needs among youth involved in the juvenile legal system; specifically, that as many as 70 percent had a diagnosable behavioral health or substance use condition.[1] These findings have fundamentally shifted the perspective of juvenile justice experts around the country over the past decade, firmly establishing the imperative that juvenile legal reform efforts include a focus on addressing the behavioral health needs of youth involved with the system.[2] Although initial uptake of this imperative focused on access to behavioral health treatment among youth already deeply involved in the juvenile legal system (e.g., detention, incarceration), forward-thinking states and jurisdictions recognized that providing behavioral health services further upstream--to youth in schools and communities--may help prevent juvenile legal system involvement altogether.

It is in this context that the School Responder Model (SRM) was first developed and implemented in eight sites across the country as part of the MacArthur Foundation Models for Change Mental Health/Juvenile Justice Action Network 2007-2011, coordinated by the National Center for Youth Opportunity and Justice (NCYOJ, then the National Center for Mental Health and Juvenile Justice [NCMHJJ]). Although specific design and implementation strategies vary among SRMs, they share two overarching and related goals: 1) to reduce the number of youth that experience in-school arrest (as well as expulsion and out of school suspension) and 2) to increase screening for behavioral health conditions and access to effective services and supports as an alternative to juvenile legal system involvement.[3] The School Based Diversion Initiative (SBDI) is an SRM that has been in operation in Connecticut since 2009, with statewide coordination provided by the Child Health and Development Institute of Connecticut (CHDI). To date, SBDI has served over 50 schools with an average reduction of 30% in school-based court referrals, and an average increase of 40% in referrals to an alternative behavioral health program.

In CHDI's more than ten year history of SBDI implementation, and in ongoing partnership working with NCYOJ and other SRM practitioners across the country, it has been discovered that the implementation of SRM is only one way in which stakeholders seek to increase the presence of behavioral health services and supports in schools. There has been an accompanying interest and need for schools to develop and expand a range of behavioral health supports and services for students, from promotion and prevention, to within-school interventions, and linkage to community-based care. Consequently, SRM practitioners must consider their work within a much broader context. *Children's Behavioral Health and Implementation of the School Responder Model* explores further the important connections among behavioral health conditions and trauma exposure, comprehensive school behavioral health practices, and SRM implementation within this context.

Behavioral Health, Trauma, and Risk for Juvenile Legal System Involvement

Behavioral health (mental health and substance use) conditions are highly prevalent in the U.S. with lifetime prevalence for any behavioral health condition estimated at 20% for youth under 18, with 5-10% of youth having a condition severe enough to significantly impair one or more critical domains of functioning.[4] Behavioral health conditions are one of several contributors to suicide, the rates of which have nearly tripled in the U.S. between 2007 and 2017 among youth 10 to 14 years old.[5] Despite the high prevalence of behavioral health conditions and suicide, around half of youth never access any kind of behavioral health treatment.[6]

Trauma exposure is also highly prevalent, with 19% reporting a lifetime prevalence of physical abuse, 71% reporting physical assault, 38% reporting witnessing community violence, and 6% reporting sexual assault.[7,8] Although some children exposed to trauma do not develop symptoms of traumatic stress, those who are impacted may experience profound impacts on brain development and functions, including judgment and decision-making, the ability to regulate emotions and behaviors, and the ability to successfully navigate relationships with peers and adults.[9] The manifestation of trauma symptoms and behavioral health conditions, in the form of dysregulated emotional and behavioral functioning, may help to explain, at least in part, why these youth have significantly higher rates of exclusionary discipline.[10] The connection between trauma and behavioral health symptoms, and the risk for juvenile legal involvement, justifies a stronger connection between the implementation of SRM within the context of comprehensive school behavioral health initiatives using a Multi-Tiered Systems of Support (MTSS) framework.

School Behavioral Health and the Multi-Tiered System of Supports Framework

Although approximately half of youth in need of treatment do not access it, those who do are most likely to do so in a school setting.[11] There are a number of reasons youth and families are less likely to access and complete treatment in community mental health centers. Structural barriers include an insufficient number of providers, insurance challenges (e.g., lack of insurance, insufficient coverage, high deductible plans), lack of transportation, inconvenient times and locations, and long wait lists. Additional concerns about the behavioral health system, regardless of the setting in which services are delivered, include concerns about privacy; lack of racially, ethnically, and linguistically diverse providers; and stigma.

The delivery of behavioral health services in schools addresses or mitigates some of these barriers by offering services in a convenient location, better coordination with schools, natural opportunities for youth and family engagement, and care provision in a comparatively less stigmatizing environment. It also helps to identify student needs earlier and connects them to appropriate interventions. Behavioral health services and supports that are well integrated with the academic curriculum have been shown to improve social-emotional and academic outcomes.[12] In the educational realm, tiered systems of services and supports, including Response to Intervention, are well-known to teachers and school personnel as a way to plan for and organize the school-wide delivery of academic supports according the degree of need among students. Similarly, scholars in the school mental health arena organize comprehensive behavioral health services and supports into a Multi-Tiered System of Supports (MTSS), most frequently using a three-tiered system of universal promotion, selective prevention, and indicated early interventions. Schools frequently assist students with more intensive behavioral health needs to access services through referral to one or more community- or hospital-based services. The multiple tiers of services can help ensure that a full continuum of supports exists, and that they work together to support optimal outcomes for all students. MTSS components may include, but are not limited to, the following:

Training school personnel in identifying and responding to behavioral health needs	**Establishing family-school-community partnership**	**Universal social-emotional learning**
Screening and assessment of behavioral health needs	**Access to in-school interventions**	**Linkages to community-based behavioral health services.[13]**

Opportunities for Coordination of MTSS and SRM

Like the implementation of MTSS, multiple components are involved in the installation and implementation of SRM:

Forming the cross-collaborative team	**Family and youth engagement**	**Determining the population of focus**
Providing an initial response to a behavioral incident	**Screening and assessment for behavioral health conditions**	**Providing effective interventions**

In addition to overlapping needs of youth in the behavioral health and juvenile legal systems, as described in the beginning of this brief, there are clear overlaps in the common elements of MTSS and SRM. As schools struggle with meeting the demands of multiple academic and non-academic initiatives, there are potential opportunities for joint coordination of planning and MTSS and SRM implementation. Below are a few examples of how MTSS behavioral health and SRM implementation efforts are related, and can be tackled together.

- **Both frameworks call for family-school-community partnerships.** The MTSS and SRM approaches work best when families are involved and engaged in the planning and implementation of the initiative, and when clinical and non-clinical community-based and grassroots organizations are key partners and potential referral sources for students with behavioral health needs.
- **Both frameworks require that school personnel have access to initial training and ongoing support.** In MTSS and SRM, school administrators, teachers and other school personnel receive training on the definition, prevalence, and impact of trauma and behavioral health conditions, and their relationships to student behavior and learning.
- **Both frameworks require selection and roll-out of evidence-based screening for trauma and behavioral health conditions.** MTSS requires that school personnel recognize possible behavioral health conditions and can conduct screening to determine whether students are in need of further assessment. Whether the precipitating incident is one that raises concerns about overall health and well-being, or places a student at risk for arrest and juvenile legal system involvement, there may be opportunities to identify common validated measures that can serve multiple purposes.
- **Both frameworks require connection to within-school and community-based behavioral health services.** Students identified as being in need of behavioral health services frequently include students who are at risk for arrest and other forms of exclusionary discipline. Effective services within the school and in the community are needed for both groups of students, and schools have the opportunity to forge such partnerships in a coordinated manner.

Conclusion

Like comprehensive school mental health using an MTSS framework, SRM are part of a suite of non-academic supports within a school system. To avoid duplication of effort and promote efficient management and coordination of such services, schools are highly encouraged to engage in shared planning, coordination, and implementation. Engaging in coordination at this level may also allow schools to tap into and integrate multiple funding streams from diverse child-serving systems that likely share a common goal around promoting upstream solutions to prevent deep-end system involvement.

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Endnotes

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